

**UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF COLUMBIA**

UNITED STATES OF AMERICA,

Plaintiff,

v.

PHILIP MORRIS USA INC.,
f/k/a PHILIP MORRIS INC., *et al.*,

Defendants.

Civil No. 99-CV-02496 (GK)

**UNITED STATES' WRITTEN DIRECT EXAMINATION OF
SURGEON GENERAL RICHARD H. CARMONA, M.D., M.P.H., F.A.C.S.
SUBMITTED BY THE UNITED STATES
PURSUANT TO ORDER #471**

1 **Q: Please introduce yourself to the Court.**

2 A: I am Richard H. Carmona.

3 **Q: What position do you currently hold?**

4 A: I am United States Surgeon General.

5 **Q: How long have you been the Surgeon General?**

6 A: It will be three years this summer.

7 **Q: What are your job responsibilities as Surgeon General?**

8 A: To protect and advance the health, safety and security of the nation.

9 **Q: Please elaborate on how you carry out your responsibilities as Surgeon General.**

10 A: I am Commander of the U.S. Public Health Service Commissioned Corps. In my role as
11 Surgeon General, I educate the public, other elected or appointed officials and the U.S. Congress
12 as to what the best science is on a particular topic. The Surgeon General communicates with the
13 public in many ways, including on talk shows, news programs, et cetera. Generally, I am the
14 spokesperson on health issues for the U.S. Government.

15 **Q: Why did you agree to testify in this case?**

16 A: I was asked to address certain issues because I am the Surgeon General and the issue of
17 smoking bears directly on the health of the nation.

18 **Q: How does smoking bear directly on the health of the nation?**

19 A: The toll on public health is enormous. Statistics show approximately 440,000 people a
20 year in the United States die prematurely from smoking. Smoking remains the largest
21 preventable cause of death in the United States.

22 **Q: Surgeon General Carmona, where did you receive your first experience in the**
23 **medical field?**

24 A: My first experience in the medical field was in the United States Army Special Forces
25 medical training. I worked as a Special Forces medic beginning in 1968.

26 **Q: What was the function of a Special Forces medic?**

1 A: We worked in teams of 12, with 2 officers and 10 enlisted men. Each of us had a primary
2 and a secondary specialty. My primary specialty was medicine and my secondary specialty was
3 weapons. The Special Forces medical specialist is known as an independent duty medic,
4 meaning you operate in a remote area with little or no supervision. Your job is to take care of
5 your team, as well as the indigenous communities in the area you work with. The Special Forces
6 today operate in a similar fashion.

7 **Q: Please describe your undergraduate degrees.**

8 A: I have an Associates Degree from Bronx Community College, which is part of the City
9 University of New York. I have a Bachelor of Science degree from the University of California,
10 San Francisco.

11 **Q: You are a medical doctor, correct?**

12 A: Yes.

13 **Q: Where did you receive your M.D. degree?**

14 A: The University of California, San Francisco.

15 **Q: When did you receive your M.D. degree?**

16 A: I received my M.D. in 1979.

17 **Q: So, you completed the requirements for your M.D. degree in three years?**

18 A: Yes; I skipped the last year of medical school and went through in 3 years. When my
19 class graduated in 1980, I was invited to be the Commencement Speaker.

20 **Q: What awards, if any, did you receive from the University of California, San**
21 **Francisco, that relate to your studies for your M.D. degree?**

22 A: I received the Gold Headed Cane Award. I also was the valedictorian and the person who
23 gave the commencement address.

24 **Q: What is the Gold Headed Cane Award?**

25 A: I felt very honored to receive the Award. The Gold Headed Cane is derived from the
26 English tradition, and is awarded to the top medical student; not just top in academics, but the

1 student who best exemplifies medicine in both academics and practice. The class, the faculty and
2 the administration all vote on it; the decision as to who receives the award is not left up to any
3 one person.

4 **Q: Following graduation from medical school, did you complete a surgical internship**
5 **and a surgical residency?**

6 A: Yes.

7 **Q: Describe your internship and residency for the Court.**

8 A: I spent 6 years at the University of California, San Francisco, did general vascular
9 surgery, and subspecialized in trauma, burns and critical care.

10 **Q: After receiving your M.D. degree, what other degrees, if any, have you received?**

11 A: I also received a Masters of Public Health Degree in Health Policy and Administration
12 from the University of Arizona in 1998. I earned this degree in night school while I was
13 working.

14 **Q: What does Health Policy and Administration entail?**

15 A: It entails oversight and management of complex health care systems and generation of
16 policies to govern public health at a local, state and national level.

17 **Q: Have you also taught medicine?**

18 A: Yes.

19 **Q: Please describe the teaching and other instruction positions that you have held in**
20 **the field of medicine.**

21 A: I held the title of Clinical Assistant Professor of Surgery at the University of California,
22 San Francisco, but I was only there for a couple of months. Shortly after graduation, I became
23 the Director of Trauma Services at Tucson Medical Center, and also – starting in 1985 –
24 progressed from Assistant Professor of Surgery at the University of Arizona, to Associate
25 Professor of Surgery, to Clinical Professor of Surgery. I held appointments in the Departments of
26 Surgery, Public Health, and Family and Community Medicine. I have also done some instruction

1 work in nursing, I have run an E.M.S. ("Emergency Medical Response") system, and I have
2 trained most of the similar components for firemen, policemen, paramedics and other first
3 responders.

4 **Q: Apart from your teaching positions, were you employed following your internship**
5 **and residency?**

6 A: I was the Director of the Southern Arizona Regional Trauma System between 1985 and
7 1993.

8 **Q: Please describe your responsibilities in that position.**

9 A: I was recruited to start and then direct the trauma services for Tucson, Arizona, which
10 included basically setting up a system for 40,000 square miles, with responsibility split between
11 the Tucson Medical Center and the University Medical Center, which were the two hospitals in
12 the system. Part of my responsibilities, which related to education, research and training, were
13 ongoing while I was providing clinical care.

14 **Q: Did you hold any other positions during that time period?**

15 A: I was also the E.M.S. ("Emergency Medical System") Chairperson for the Southern
16 Region of Arizona and had concomitant responsibilities during this time period with the Sheriff's
17 Department.

18 **Q: What was the next position you held after that?**

19 A: I was the Chairperson of the Pima County Blue Ribbon Health Care Commission between
20 1994 and 1995.

21 **Q: What was the Commission's purpose?**

22 A: We studied the Pima County Health Care System for one year and wrote a report
23 reviewing the county's health care assets and recommending future options.

24 **Q: Were the Commission's recommendations accepted?**

25 A: Yes; all of the Commission's recommendations were accepted and implemented, which
26 resulted in an integrated health care system.

1 **Q: What was the next position you held?**

2 A: In 1995, I was asked to be the CEO and Medical Director of Pima County Hospital in
3 Arizona. By the second year, I was CEO of the entire health care system. I held that position
4 until 2000.

5 **Q: What were your responsibilities as CEO of the Pima County Hospital?**

6 A: I had responsibility for revenue, expenses and profitability at the hospital. I was
7 essentially running a small corporation: the hospital. I was also practicing medicine part-time. I
8 was responsible for anything and everything happening in the hospital, including the fiscal side
9 and the medical side. I also kept my responsibilities as a professor.

10 **Q: How did your position grow from CEO of Pima County Hospital to the CEO of the**
11 **entire Pima County Health Care System?**

12 A: At first, I reported to the County Manager as CEO of the Hospital. Then I became the
13 CEO of the entire Pima County Health System.

14 **Q: What were your responsibilities as CEO of the Pima County Health Care System?**

15 A: My responsibilities as CEO of the entire Health Care System were much more diverse. I
16 was tasked to oversee and arrange a complex health care system, including EMS, patient
17 services, clinics, and the like. This included policy-level decisions all the time. The trauma
18 position that I had previously held included policy decisions, but this position included more
19 global policy at the county, regional and state levels, and also included federal involvement
20 relating to agencies such as the Health Care Financing Administration, a sub-component of the
21 United States Department of Health and Human Services.

22 **Q: Earlier you mentioned that you had responsibilities with the Sheriff's Department.**
23 **In addition to teaching medicine and providing medical services in the civilian and military**
24 **contexts, did you also hold positions in law enforcement?**

25 A: Yes. I had a dual position in law enforcement, both as a police officer and as a Medical
26 Director, which is also referred to as the Department Surgeon, with the Pima County Sheriff's

1 Department.

2 **Q: Please describe the specific positions that you held in the law enforcement context**
3 **and your responsibilities in those positions.**

4 A: In 1985, I started as a reserve officer in the Department of Public Safety, and I started
5 with the Air Rescue Unit. Many years later, I delegated this position to a subordinate. Toward
6 the next year, the S.W.A.T. ("Special Weapons and Tactics") leader asked me to join and start a
7 medical program. I did this, and started the Tactical Medical Program. This expanded to
8 overseeing the jail as its Medical Director, from law enforcement to medical and/or public health.
9 These responsibilities continued until my appointment as Surgeon General in 2002.

10 **Q: Have you also held medical advisory positions with the U.S. Government prior to**
11 **becoming the Surgeon General?**

12 A: Yes. From the mid-80s well into the 1990s, I held the position of Medical Support
13 Liaison with the United States Secret Service and the State Department. This was an unpaid
14 advisory position, which started with a call from Colonel John Hutton, who was President
15 Reagan's personal physician. I worked in an advisory capacity with the U.S. Secret Service out
16 of Tucson, Arizona, I helped the Secret Service set up some medical programs for the President
17 and Vice President, and I also actually set up medical programs for them.

18 **Q: Was this position at a national level?**

19 A: This started at the local level, and then grew to the state and national levels.

20 **Q: Did you have any other duties in this position?**

21 A: Yes; I helped to develop tactical medical support and support for dignitaries should the
22 need arise, developed standard operating procedures for their care and developed core
23 competencies for their care – determining what equipment was necessary and how to provide
24 medical treatment for trauma or general medical care.

25 **Q: Have you held any other positions with the United States Government?**

26 A: Yes; I was also a Medical Support Liaison for the Department of Defense Special

1 Operations Command. I began in an advisory capacity, then became faculty at U.S.U.H.S. (the
2 “Uniformed Services University for Health Sciences”). By 2002, I was given the title
3 Distinguished Professor of Military Medicine.

4 **Q: What do you teach there?**

5 A: I have been on the faculty since the late 1980s, teaching combat tactical care, counter-
6 narcotics, counter-terrorism tactical support, and similar instruction.

7 **Q: When did you begin in your position as Medical Support Liaison for the**
8 **Department of Defense Special Operations Command?**

9 A: I began in the mid-1980s and continued for several years. I was Coordinator/Liaison for
10 the Special Operations divisions of the military.

11 **Q: Now let's turn to your actions as the Surgeon General. Are you the signatory of any**
12 **of the Surgeon General's Reports on smoking?**

13 A: Yes; the 2004 Surgeon General's Report.

14 **Q: When was the 2004 Surgeon General's Report – U.S. Exhibit 88,621 – released?**

15 A: The 2004 Report was released May 27, 2004.

16 **Q: The Court has already heard extensive testimony from other witnesses – including**
17 **Drs. Samet, Burns, Eriksen, Benowitz and Henningfield – about the preparation of**
18 **Surgeon General's Reports, so we do not need to ask you to testify in detail about that.**
19 **Instead, I'd like you to focus upon the next steps necessary to reduce the harm caused by**
20 **cigarette smoking. Is there a chapter of the 2004 Report that addresses this issue?**

21 A: Yes; Chapter 8.

22 **Q: What is the subject-matter of this chapter?**

23 A: This is a vision for the future, and the chapter basically summarizes the general progress
24 in the last 40 years or so, and then goes on to review the need for a continued, sustained, effort, a
25 comprehensive approach, and a comprehensive plan for the future.

26 **Q: What was your role in the creation of the 2004 Surgeon General's Report?**

1 A: My primary role was as the chair/convener of many of the meetings of the experts in the
2 field, who convened to exchange the best evidence and science as it relates to the health
3 consequences of smoking. The Surgeon General tends to be the orchestra leader, who makes
4 sure due diligence has been performed. We are the ones driving the due diligence, holding the
5 appropriate feet to the fire on these issues.

6 **Q: Was there any sort of abbreviated companion Report that accompanied the 2004**
7 **Report?**

8 A: There is a People's Piece that accompanies the 2004 Report, and that is something that I
9 started doing with Surgeon General's Reports, to make sure the American public can understand
10 the complex science. We wanted to write the Report for scientists, but we also wanted to engage
11 the American public, so we broke it down into simple, understandable layperson's language.

12 **Q: Please describe the "People's Piece" for the Court.**

13 A: It is intended to be accessible to people of different educational levels and to
14 communicate with diverse groups, to allow communication with the American public. The
15 People's Piece ensures that the American public is engaged by the science in the 2004 Surgeon
16 General's Report.

17 **Q: Please review U.S. Exhibit 88,664. What is this exhibit?**

18 A: This is the People's Piece of the 2004 Surgeon General's Report, the Health Consequences
19 of Smoking.

20 **Q: To your knowledge, is the 2004 Report the first Surgeon General's Report on**
21 **smoking and health to have such a "People's Piece"?**

22 A: Yes; I think we have done one for the Surgeon General's Report on Osteoporosis and one
23 for the 2004 Report on Smoking and Health.

24 **Q: Why was the "People's Piece" created?**

25 A: The People's Piece is a mechanism for us to ensure that the American public is engaged in
26 this issue; that the best science we have is delivered in an understandable and culturally

1 competent manner. This is bilingual now – in English and Spanish, and we are looking at putting
2 this in other languages.

3 **Q: Is the "People's Piece" something that you believe is important?**

4 A: Absolutely; I think it is a real breakthrough. The People's Piece allows communication of
5 this information with the American public, and it is our attempt to make sure that this
6 information is used by the public and will hopefully change behavior where need be. It is
7 succinct and could be used by families to educate their kids, for example.

8 **Q: Do you view the People's Piece as a part of the 2004 Report?**

9 A: Absolutely; I do. Yes.

10 **Q: Does the "People's Piece" present some of the main conclusions of the 2004 Surgeon
11 General's Report?**

12 A: It does; in a very understandable way, it explains what smoking is doing to every part of
13 your body.

14 **Q: Did the Department of Health and Human Services also produce an accompanying
15 website and CDs, or "compact discs," relating to the health consequences of smoking?**

16 A: Yes.

17 **Q: Please describe the website.**

18 A: You can access it from www.hhs.gov, www.surgeongeneral.gov, and, I believe, other web
19 sites. The website has the 2004 Surgeon General's Report – it is essentially the Report and the
20 People's Piece online.

21 **Q: Is the 2004 Surgeon General's Report also available on CD?**

22 A: Yes.

23 **Q: And did the Department of Health and Human Services also produce a CD that
24 visually depicts the health consequences of smoking?**

25 A: Yes.

26 **Q: Please review U.S. Exhibit 88,660. Is this a copy of the CD?**

1 A: Yes.

2 **Q: Please describe this CD for the Court.**

3 A: The CD is an interactive CD which allows a person to have visual reinforcement of some
4 of the concepts, so if you want to see what a normal and diseased lung looks like, or see a fetus in
5 utero and see how the fetus is affected by smoke, you can. It displays how smoking is not just in
6 your lung, but affects every cell in your body. We're very proud of the website and the CDs.

7 **Q: Does the Department of Health and Human Services also maintain an interactive**
8 **web-based site that contains the same information as the interactive CD?**

9 A: Yes; I believe it is available at the following website:

10 www.cdc.gov/tobacco/sgr/sgr_2004/sgranimation/flash/index.html

11 **Q: How do the websites and the CDs help to communicate with the public about the**
12 **health consequences of smoking?**

13 A: They are another portal of access for the citizens; some are computer literate – enjoy
14 searches on the web and have access to a computer; some prefer hardcopy or do not have access
15 to a computer. So we try to utilize all aspects of these areas, so that they can be as effective as
16 possible.

17 **Q: Please describe what the Surgeon General's Office and the Department of Health**
18 **and Human Services did, if anything, to ensure that the People's Piece would effectively**
19 **communicate with the general public.**

20 A: We had educational specialists come in and determine the educational level at which the
21 People's Piece should be written. We sought input from a number of health literacy experts, who
22 recommended that it be at a 6th and 7th grade level, and they also reviewed the content of the
23 People's Piece after a draft was written, to be certain that it was written at the proper literacy
24 level.

25 **Q: How many copies of the People's Piece have been distributed?**

26 A: My understanding is that over 162,500 copies of the People's Piece have been distributed

1 as of April 6th of this year.

2 **Q: Describe the audiences that have ordered and received the People's Piece.**

3 A: The primary audiences have included schools – ranging from elementary to university
4 levels, as well as specialized schools – medical centers, health agencies, non-governmental
5 organizations, extracurricular programs such as the Girl Scouts and Boys and Girls Clubs,
6 churches and private citizens.

7 **Q: Has the People's Piece won any awards?**

8 A: Yes.

9 **Q: What awards has the People's Piece won?**

10 A: The People's Piece has won two awards that were given by the Society for Technical
11 Communications. The first was the Society for Technical Communications East Tennessee
12 Chapter Award for Distinguished Technical Communication, in the Information Materials
13 Category. The second award was the Society for Technical Communications International
14 Competition Award for Excellence in Technical Communication, also in the Informational
15 Materials Category.

16 **Q: Let's return to the 2004 Surgeon General's Report. You wrote the Preface to the**
17 **2004 Surgeon General's Report, correct?**

18 A: Yes.

19 **Q: In the last two paragraphs of your preface, do you make statements reflecting what**
20 **remains to be done regarding cigarette smoking?**

21 A: Yes.

22 **Q: What do you say in your Preface on this issue?**

23 A: "I am encouraged by the declining smoking rates in the United States in recent decades.
24 However, every day nearly 5,000 people under 18 years of age try their first cigarette, and in
25 2001, an estimated 46.2 million American adults smoked. These numbers represent an enormous
26 emotional and financial burden for their families and for our health care system. This report

1 documents the path leading to disease and death that these smokers inevitably face if they
2 continue to smoke.

3 Over the years the harmful effects of smoking have been well documented. Although
4 great progress has been made, a challenging struggle remains. This report will hasten the day
5 when many of the findings herein are no longer true and we will be able to view smoking as a
6 scourge of the past. We all need to strengthen our efforts to prevent young people from ever
7 starting to smoke, and to encourage smokers of all ages to quit."

8 **Q: Do your statements relate to future actions for tobacco control?**

9 A: They refer to not only future but to present actions.

10 **Q: Now let's turn to Chapter 8 of the 2004 Surgeon General's Report, which we briefly**
11 **discussed earlier. What is the title of Chapter 8 of the 2004 Report?**

12 A: "A Vision for the Future."

13 **Q: In the introduction to Chapter 8, are there statements about future actions for**
14 **tobacco control?**

15 A: Yes; it states: "The courses of action highlighted below are potential next steps presented
16 by the Surgeon General. Given his role as the nation's spokesman on matters of public health,
17 these recommendations represent a vision for the future built on information available today."

18 **Q: Do you consider the potential future actions relating to cigarette smoking that are**
19 **outlined in Chapter 8 of the 2004 Surgeon General's Report to be among the next steps that**
20 **you recommend as the Surgeon General?**

21 A: Yes.

22 **Q: Now I would like to cover a few general concepts that permeate Chapter 8 of the**
23 **2004 Report. Does the Introduction to Chapter 8 refer to "efforts to prevent and control**
24 **tobacco use"?**

25 A: Yes.

26 **Q: And does Chapter 8 also contain numerous references to efforts to prevent, control**

1 **and/or reduce tobacco use?**

2 A: Yes.

3 **Q: What do efforts to "control tobacco use" entail?**

4 A: They entail both prevention and cessation.

5 **Q: Are smoking cessation programs an important component of your "Vision for the**
6 **Future" in Chapter 8 of the 2004 Report?**

7 A: Yes.

8 **Q: Why?**

9 A: They are an important component, because there are still too many people smoking.

10 **Q: Now let's turn to your reference to efforts to "prevent" tobacco use. What do these**
11 **efforts entail?**

12 A: In the most general fashion, they entail educating the public as to the risks of beginning
13 smoking and why they shouldn't.

14 **Q: Let's talk about prevention in general. Is an emphasis on disease prevention – as**
15 **distinguished from treatment – one of your priorities as Surgeon General?**

16 A: Yes; absolutely. It is one of the main priorities in my portfolio, as it relates to all medical
17 problems that are preventable.

18 **Q: Is disease prevention also a priority of the Administration?**

19 A: Yes.

20 **Q: Please explain why it is important to focus on prevention.**

21 A: The importance of prevention is self-explanatory. It prevents you from getting a disease,
22 improves the quality of your life, and reduces your need to use health care.

23 **Q: In your view, does that reasoning apply equally to support tobacco prevention?**

24 A: Yes.

25 **Q: Now I would like to talk about the section of Chapter 8 entitled "The Need for a**
26 **Sustained Effort." Is it fair to say that this section sets forth some of the harm caused by**

1 **smoking today?**

2 A: Yes; that is a fair statement.

3 **Q: What is the first statement in this section?**

4 A: "Smoking remains the leading preventable cause of disease and death in the United
5 States, resulting in more than 440,000 premature deaths each year."

6 **Q: Paragraph two of this section states that "the data indicate that future reductions in
7 the morbidity, mortality, and economic costs of tobacco use will require a continuing and
8 sustained effort," correct?**

9 A: Yes.

10 **Q: Why is it important to have a continuing and sustained effort?**

11 A: If we do not have a continuing and sustained effort, the smoking rates, the death rates and
12 the complication rates will rise.

13 **Q: What does this paragraph say about the smoking rates of some minority populations
14 and among Americans who are less educated?**

15 A: That they tend to be higher.

16 **Q: Why is that significant?**

17 A: It demonstrates that there are health disparities among different groups relating to
18 smoking.

19 **Q: Now I would like to turn your attention briefly to U.S. Exhibit 89,325. What is this
20 exhibit?**

21 A: This is a weekly publication of CDC called the Morbidity and Mortality Weekly
22 Reporter, used to disseminate health information. It has an article on the 40th Anniversary of the
23 first Surgeon General's Report, and the second column has an article that I was involved in
24 relating to "Prevalence of Cigarette Use Among 14 Racial/Ethnic Populations — United States,
25 1999-2001."

26 **Q: What is the date of the article?**

1 A: It is dated January 30, 2004.

2 **Q: Are you credited as a co-author of this article?**

3 A: Correct.

4 **Q: Please explain your involvement with the creation of this article.**

5 A: I was aware first that my colleagues were involved in this article, specifically Dr.
6 Caraballo. He spoke with me about it, specifically asking would I be a coauthor and contribute
7 to it. My part was mainly reviewing this report, making suggestions and adding to this article.

8 **Q: To what extent, if any, did your work on this article relate to applying the findings**
9 **of these studies to developing tobacco control programs?**

10 A: It supports the fact that we need to do a lot more in high-risk populations, minority
11 populations and youth, for example, to prevent them from starting, or if they have started, to help
12 them to quit. We did not develop any specific new programs as a result, but we certainly have
13 ongoing programs, the continuation of which is supported by this article.

14 **Q: Insofar as it relates to your duties as Surgeon General, why is that important to**
15 **have effective tobacco control programs?**

16 A: Part of my job is protect and advance the health of the nation, and when you have a
17 problem that is killing 400,000-plus people a year, it's important to get this information out.
18 This information also helps to guide our program development.

19 **Q: What is stated in the last sentence of the first paragraph on the issue of reducing the**
20 **use of tobacco among certain racial and ethnic populations?**

21 A: "Implementing tobacco-control programs that include culturally appropriate interventions
22 can help reduce tobacco use among racial/ethnic populations."

23 **Q: Do you still agree with this statement?**

24 A: Yes; very strongly.

25 **Q: Are culturally appropriate interventions also important in reaching all populations**
26 **in the United States on issues of smoking and health?**

1 A: Yes. You won't be successful unless you consider culture and language.

2 **Q: Please turn to the "Editorial Note," and tell the Court what is stated in the last two**
3 **sentences of the second-to-last paragraph.**

4 A: "Racial/ethnic minority populations commonly have less access than non-Hispanic whites
5 to culturally and linguistically appropriate anti-smoking educational materials, media messages,
6 and cessation services. Moreover, racial/ethnic minority populations have been targets of
7 tobacco industry marketing efforts, including sponsorships of cultural events and funding of
8 organizations."

9 **Q: Please explain the significance of this information.**

10 A: The significance is that, first, as stated, racial and ethnic minorities typically have less
11 access than non-Hispanic whites to appropriate cessation and prevention assistance, and that
12 these same populations have been targets of the tobacco industry. The industry continues to
13 target these groups, and if you're trying to get them to quit, you need culturally competent
14 communications.

15 **Q: Please tell the Court what is stated in the last paragraph of the "Editorial Note,"**
16 **relating to initiatives to reduce tobacco use among racial and ethnic subsets of the**
17 **population.**

18 A: Essentially, that culturally competent interventions are needed to prevent increases in
19 smoking and to cause decreased smoking in populations with high prevalence. They propose
20 initiatives, and then list several. All of them are targeted at reducing the disparity of minority
21 smoking.

22 **Q: What are these initiatives?**

23 A: "1) increasing the capacity (i.e., through increased funding for program development,
24 training, evaluation, and research) of specific populations to address tobacco use within their
25 communities;

26 2) conducting educational campaigns that are culturally competent and targeted to the

1 specific needs and concerns of racial/ethnic populations; and

2 3) drawing on the strengths and assets of these racial/ethnic communities."

3 **Q: And what is the concluding statement of the article?**

4 A: "Tobacco-control initiatives based on these practices can reduce disparities related to
5 smoking prevalence, exposure to secondhand smoke, and the burden of smoking-related disease."

6 **Q: Are these recommended actions also applicable to tobacco control efforts for the
7 United States population at large?**

8 A: Absolutely; yes.

9 **Q: What would be included in an effective strategy to reduce the higher smoking
10 prevalence of Americans who are minorities and Americans who are less educated?**

11 A: Culturally competent, evidence-based practices for smoking cessation.

12 **Q: Now let's discuss some other work you have done in this area as the Surgeon
13 General. Another route through which you are involved in federal government actions
14 relating to smoking is the Interagency Committee on Smoking and Health, correct?**

15 A: Yes; as Surgeon General, I am the chair and I attend as many of the meetings as possible,
16 and I report developments of the Interagency Committee to the Secretary.

17 **Q: What is the Interagency Committee on Smoking and Health?**

18 A: The Interagency Committee was established by Congress in 1984. The Committee
19 reports to the Secretary of HHS. It is staffed by the CDC's Office on Smoking and Health. The
20 Committee is charged with helping to coordinate the Department of Health and Human Services'
21 research, educational programs and other activities relating to smoking and health. It also
22 provides a liaison function to appropriate private organizations and to federal, state and local
23 public health agencies regarding smoking and related programs.

24 **Q: Have there been any special areas of focus for the Interagency Committee since you
25 became Surgeon General?**

26 A: Well, there are a few that have followed developments from prior years. For instance, the

1 Cessation Subcommittee of the Interagency Committee on Smoking and Health held its first
2 meeting during my tenure as Surgeon General, but it was developed while Dr. David Satcher, my
3 predecessor, was the Surgeon General. We have had meetings of the Interagency Committee on
4 Smoking and Health where we discussed various topics relating to smoking and health, including
5 cessation, prevention, and health disparities relating to smoking.

6 **Q: Now I would like to return to the 2004 Surgeon General's Report, and turn your**
7 **attention specifically to page 899, which contains the section of Chapter 8 entitled "The**
8 **Need for a Comprehensive Approach." Do you see that?**

9 A: Yes.

10 **Q: Does this section discuss some of the public health approaches that can be used to**
11 **reduce the harm caused by cigarette smoking?**

12 A: Yes.

13 **Q: What does the Report say about the use of a "comprehensive approach" in tobacco**
14 **control and the science base for it?**

15 A: The Report states that we need a comprehensive program and that it needs to be strongly
16 evidence-based, which all of our programs are.

17 **Q: Is there any discussion in this section of the relationship between changes in**
18 **smoking behaviors and the level and continuity of investments in comprehensive program**
19 **efforts?**

20 A: Yes; there's a direct relationship between the amount of resources in that area and the
21 expected success of either preventing or stopping smoking.

22 **Q: Does this paragraph discuss – continuing on the right column – what is required for**
23 **a comprehensive national effort for tobacco control?**

24 A: Yes; that's correct.

25 **Q: Does it state that "a comprehensive national tobacco control effort requires**
26 **strategies that go beyond guidance to the states"?**

1 A: Yes.

2 **Q: Does the last paragraph of this section explain why a comprehensive tobacco control**
3 **effort is needed?**

4 A: Yes.

5 **Q: What does it say – in the first two sentences of this paragraph – on that topic?**

6 A: "There is a need for a continuing and sustained national tobacco use prevention and
7 control effort. Many factors encourage tobacco use in this country: the positive imagery of
8 smoking in movies and in the popular culture, the billions of dollars spent by the tobacco
9 industry to advertise and promote cigarettes (e.g., \$11.2 billion in 2001 [Federal Trade
10 Commission 2003]), acceptance of secondhand smoke in public places, and the perception by
11 some that the problem has been solved."

12 **Q: Do you still agree with the statement in your recommendations for future action that**
13 **specifically lists "the billions of dollars spent by the tobacco industry to advertise and**
14 **promote cigarettes" as one of the main factors encouraging tobacco use in this country?**

15 A: I agree with that, and that is one of the reasons you need a multi-level strategy; to combat
16 this.

17 **Q: Please tell the Court what is stated in the remainder of the paragraph.**

18 A: "Additionally, funding levels for many effective state and national counter-advertising
19 campaigns were recently reduced. We know enough to take action. As in many areas of public
20 health, there is a need to improve the dissemination, adoption, and implementation of effective,
21 evidence-based interventions, and to continue to investigate new methods to prevent and reduce
22 tobacco use."

23 **Q: Please turn now to the last section of Chapter 8. What is the title of this section?**

24 A: "Tobacco Control in the New Millennium."

25 **Q: What is stated in this section entitled "Tobacco Control in the New Millennium"**
26 **regarding the rates of tobacco-related illnesses and death?**

1 A: "Unfortunately, the high rates of tobacco-related illnesses and deaths will continue until
2 tobacco prevention and control efforts worldwide are commensurate with the harm caused by
3 tobacco use."

4 **Q: As Surgeon General of the United States, do you agree with that statement?**

5 A: I see it, I understand it, and I agree with it.

6 **Thank you, Surgeon General Carmona.**